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No. 95-1858 and No. 96-110

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In the Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, ET AL.,
PETITIONERS,
v.
TIMOTHY E. QUILL, ET AL.,
RESPONDENTS.
and
STATE OF WASHINGTON,
PETITIONERS,
v.
HAROLD GLUCKSBERG, ET AL.,
RESPONDENTS.

On Appeal from the United States Courts of Appeals for the Second Circuit and Ninth Circuit

BRIEF FOR BIOETHICS PROFESSORS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTIONS PRESENTED

Is there a difference between the constitutional right of a competent adult to refuse medical treatment, including life-sustaining medical treatment, and the right of a competent, terminally ill adult to have a physician prescribe lethal medication for the purpose of committing suicide?

Does the constitutional right of a pregnant woman to terminate a pregnancy by a physician-performed or prescribed medical procedure support a constitutional right of a competent, terminally ill adult to have a physician prescribe lethal medication for the purpose of committing suicide?

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Interest of Amicus

Amicus is an ad hoc group of 50 professors who teach medical ethics to medical students and/or physicians in universities, medical schools, and clinical settings. The Amicus professors include philosophers, theologians, attorneys, and physicians of different religious backgrounds who have a major professional interest in medical ethics. The Amicus group strongly believes that permitting competent adults to refuse any medical treat-

ment is a fundamental right consistent with medical ethics, is independent of any purported right to physician assisted suicide, and should continue to be protected by the Court. The Amicus group also strongly believes that a woman's constitutional right to decisionmaking regarding abortion in the privacy of the physician-patient relationship should continue to be protected independent of any purported right to physician assisted suicide. Amicus has obtained the written consent of the parties in both actions to filing this brief. (Letters confirming the parties' consent have been filed with the Clerk of the Court.)

Summary of Argument

I

The analytical basis for both the Ninth and Second Circuit Courts of Appeals opinions is that there is no difference between the right of all competent people to refuse recommended medical treatment and the right to physician assisted suicide. There are, however, major differences between the right to refuse medical treatment and the right to physician assisted suicide. The right to refuse treatment is rooted in the history and traditions of this country. It is the expression of the venerable and universally recognized right of all individuals to be free from unwanted and nonconsensual physical invasions of their bodies. All courts that have decided the issue until now have readily distinguished between suicide and refusing treatment, and have permitted the refusal of medical treatment while still recognizing the state's interest in the prevention of suicide.

For these reasons the Court can refuse to recognize a constitutional right to physician assisted suicide and still recognize both constitutional and common law rights to refuse treatment.

II

The Ninth Circuit Court of Appeals' decision derived the

right to physician assisted suicide from the Court's cases that recognize a woman's constitutional right to decide whether or not to terminate her pregnancy. This is mistaken because those cases are specifically directed at enabling a woman to make choices she believes further her health and continued participation in society, whereas assisted suicide leads only to death.

If it is true that people have the constitutional right to commit suicide and, therefore, the constitutional right to assistance in their suicide, there is no reason why this right is limited to assistance from physicians. Unlike abortion, neither suicide nor assisted suicide is a medical procedure.

There is no basis in logic or constitutional law to limit the right to assisted suicide to terminally ill patients. There is no accepted definition of terminal illness, and it is difficult, if not impossible, for physicians to accurately predict any particular individual's life expectancy.

For these reasons the Court can refuse to recognize a constitutional right to physician assisted suicide and still recognize a woman's constitutional right to decide whether or not to terminate a pregnancy.

Argument

I. THE RIGHT OF A COMPETENT INDIVIDUAL TO REFUSE MEDICAL TREATMENT IS UNIVERSALLY RECOGNIZED, IS DEEPLY ROOTED IN THE HISTORY AND TRADITIONS OF THE UNITED STATES AND HAS NEVER BEFORE BEEN EQUATED WITH SUICIDE BY AN APPEALS COURT OR A LEGISLATURE.

A. *The Right of a Competent Individual to Refuse Medical Treatment is Universally Recognized and Deeply Rooted in the History and Traditions of the United States.*

The major premise upon which both the Ninth Circuit Court of Appeals in *Compassion in Dying* v. *Washington*, 79

F.3d 790 (9th Cir. 1996), and the Second Circuit Court of Appeals in *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir. 1996), rely to find that there is a constitutional right to physician assisted suicide is that there is no rational distinction between physician assisted suicide and the right of an individual to refuse life-saving medical treatment. This premise is not only incorrect, but threatens the well established right to refuse treatment.

The Ninth Circuit Court of Appeals mistakenly believes that the right of individuals to refuse treatment is a modern invention that was only recently bestowed upon individuals by the courts. It states, "The first major breakthrough occurred when the terminally ill were permitted to reject medical treatment." 79 F.3d at 821, citing *Satz* v. *Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980). The Ninth Circuit Court of Appeals refers to the recognition of the rights of individuals both to refuse and to terminate medical treatment, as "drastic changes regarding acceptable medical practice. . . ." 79 F.3d at 822. To reach this conclusion, the court must have believed that until the 1970's the law permitted patients to be forcibly treated. This demonstrates a profound misunderstanding of the source and application of the right to refuse treatment. It was not until 1912 "when for the first time in human history . . . a random patient with a random disease consulting a doctor chosen at random stood a better than 50-50 chance of benefiting from the encounter." RICHARD HARRIS, A SACRED TRUST 5 (1966). Since medicine had little effective treatment to offer prior to this century, there was no reason to ever attempt to force treatment on patients. When the consent issue did come before courts, their decisions were clear. In 1905, for example, an Illinois court held:

> Under a free government at least, the free citizen's first and greatest right which underlies all others — the right to the inviolability of his person, in other words, his right to himself — is the subject of universal acquiescence, and

> this right necessarily forbids a physician . . . to violate, without permission, the bodily integrity of the patient by a major or capital operation.

Pratt v. *Davis*, 118 Ill. App. 161 (1905), *aff'd* 224 Ill. 300, 79 N.E. 562 (1906).

Similarly, in a 1914 New York case, Justice Brandeis wrote, "every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ." *Schloendorff* v. *Society of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

The principles of bodily integrity and self-determination are so basic that they seem to need no justification. Nothing empowers the state to require a free living, competent adult to always comply with medical advice. Such a rule would convert medical advice into medical tyranny. One searches in vain to find a case in which free living competent adults are restrained against their will and forced to submit to treatment by physicians. The law is entirely in the other direction — competent adults are under no legal obligation to submit to offered treatment. The laws of battery and informed consent are barriers against unwanted treatment. *Cobbs* v. *Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Canterbury* v. *Spence*, 464 F.2d 772 (D.C. Cir. 1972), *cert. denied* 409 U.S. 1064 (1972).

The case law throughout the United States is consistent and unequivocal: competent adults have the right to refuse any medical treatment, and the exercise of this right is not contingent on suffering from a terminal illness. In *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (1978), for example, a 72-year-old man refused to have his gangrenous legs amputated. He was not terminally ill or comatose. He could live indefinitely if he submitted to the recommended treatment but would soon die if he refused the treatment. The court found that this competent man could refuse such life saving treatment. Similarly, in *Lane* v. *Candura*, 6 Mass. App. Ct. 373, 376 N.E.2d 1232 (1978), the Massachusetts appeals court

found that a competent 77-year-old woman could refuse a life-saving amputation of her foot. She was not terminally ill and could live indefinitely if the procedure were performed. As the court concluded, "we are all of the opinion that the operation may not be forced upon her against her will." 6 Mass. App. Ct. at 384, 376 N.E.2d at 1236.

Failure to honor this right leads to horrific consequences. William Bartling, a 70-year-old man who was suffering from five potentially fatal illnesses, was so insistent on refusing treatment that he had removed his ventilator himself on several occasions. In response, the physicians ordered his hands tied to his bed. The trial judge ruled that his ventilator could not be removed because Mr. Bartling was not terminally ill, comatose, or brain dead. Since none of these conditions are prerequisites for treatment refusal, the California Court of Appeals reversed. It ruled that a competent adult could refuse any treatment, including life-sustaining treatment, and that the act of removing a ventilator at the patient's demand was no different legally from not attaching a ventilator in the first place. *Bartling* v. *Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (2d Dist. 1984). No competent person should ever be forcibly treated in this country, and appellate courts have consistently confirmed this principle.

The principle of consent with its complementary right to refuse and withdraw consent is fundamental. How could it be otherwise? What power could be called upon that would permit the state to forcibly amputate the limbs of competent people? Certainly the *parens patriae* power does not apply to competent people, and the police power does not apply where the person's decision only affects him- or herself.[1] Absent

[1] There is no doubt that the state, in the exercise of its police powers, has the authority to limit the exercise of an individual's autonomy for the purpose of protecting the public's health. *See, Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905). But even in that case, the Court did not rule that Jacobson could be forcibly vaccinated. Rather it held that he could be fined for failure to comply with the city's mandatory vaccination order. Those who suffer from contagious diseases, such as tuberculosis, and who refuse treatment that would render them noninfectious can be isolated from the general population. *Greene* v. *Edwards*, 164 W.Va. 326, 263 S.E.2d 661 (1980).

the right to refuse medical treatment, all persons would be required to submit themselves to any treatment a physician recommends. It is estimated that approximately 70 percent of the deaths in hospitals today follow some decision to withhold or to stop treatment. THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 147 (1994). In an era in which most people die in hospitals or nursing homes, this opens the possibility of all patients being forcibly subjected to an unlimited onslaught of medical interventions at the end of life. Nothing in American law permits this absent patient consent.

This Court has recognized the individual's strong interest in avoiding unwanted treatment. The Court noted, "The *forcible injection of medication* into a nonconsenting person's body represents a substantial interference with that person's liberty." *Washington* v. *Harper*, 494 U.S. 210 (1990) (emphasis added). In *Cruzan* the Court stated "The principle that a competent person has a constitutionally protected liberty interest in refusing *unwanted medical treatment* may be inferred from our prior decisions." *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), 497 U.S. at 278 (emphasis added). Justice O'Connor, in her concurring opinion, said, "Requiring a competent adult to endure *such procedures against her will* burdens the patient's liberty, dignity and freedom to determine the course of her own treatment." 497 U.S. at 289 (emphasis added).

The belief of both Circuit courts that there was a time in American law when a competent individual could not refuse medical treatment may come from a misreading of a few cases from the 1960s that involved Jehovah's Witnesses who refused blood transfusion as a result of their religious beliefs. The patients involved were not terminally ill and would likely

recover and live long, healthy lives if this relatively minor physical intrusion was allowed.

Perhaps the most widely cited of these cases is *Application of the President and Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964). In this case, a 25-year-old woman was brought to the hospital with a bleeding ulcer, having lost two-thirds of her blood. Both the patient and her husband were Jehovah's Witnesses. The judge spoke to the husband, and wrote, "He advised me that on religious grounds he would not approve a blood transfusion for his wife. He said, however, that if the court ordered the transfusion, the responsibility was not his." When the judge went to the patient's room he found that "It was obvious that the woman was not in a mental condition to make a decision." The judge asked her if she would oppose a transfusion if he authorized it and reported, "She indicated, as best I could make out, that it would not then be her responsibility." The judge then authorized the blood transfusions. This is not a case of *forcible* treatment being inflicted on a competent patient. Rather it is a case in which neither the incompetent patient nor her husband could consent to the blood transfusion because of their religious beliefs, but made it clear to the judge that they did not oppose his authorization of the treatment. The patient and her husband were relieved to have the judge make this decision for them.[2]

United States v. *George*, 239 F.Supp. 752 (D. Conn. 1965),

[2] Although a petition for a rehearing *en banc* was denied for technical reasons, a number of judges expressed the opinion that the single judge who decided this case had no authority to do so, and that if he did have such authority, his decision was wrong. 331 F.2d at 1010. Circuit Judge (later Chief Justice) Burger asks in his opinion, "If the patient has objections to that treatment based on religious conviction, or if he rejects the medical opinion, are the courts empowered to decide for him?" 331 F.2d at 1017. He later answers this question by stating, ". . . there are myriads of problems and troubles which judges are powerless to solve; and this is as it should be. Some matters of essentially private concern and others of enormous public concern, are beyond the reach of judges." 331 F.2d at 1017-18.

is similar. In this case the judge explained that he had no power to *order* the transfusion and that the patient would be free to resist the transfusion by merely putting his hand over the site where the needle would be inserted. The patient responded he would in no way resist the transfusions once the judge signed the order. Again, this is the case of a person who could not affirmatively consent to a transfusion because of his religion, but who did not oppose being treated.

These cases can be compared to *In re Osborne*, 294 A.2d 372 (D.C. App. 1972), in which a 34-year-old father who was seriously injured in an accident refused a life-saving blood transfusion. Mr. Osborne told the judge, "It is between me and Jehovah, not the courts . . . I'm willing to take my chances. My faith is that strong. I wish to live but with no blood transfusions." No transfusion was authorized in this case.[3]

Far from supporting governmental authority to violate the bodily integrity of competent individuals, these cases demonstrate the respect judges have traditionally shown for individual autonomy in regard to the receipt or refusal of medical care. They have enabled those who wish to receive such care to obtain it, and have protected the bodily integrity of those who did not wish to receive the offered care.

The right defined and protected in all the right to refuse treatment cases is the right to be free from unwanted bodily intrusions. It is not the "right to die" or to determine "the time and manner of one's own death" or to "hasten" one's death.

[3] Other cases in which individuals were found to have the right to refuse life-saving blood transfusions include *Matter of Melideo*, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (1976) (23 year old woman could refuse blood transfusion to save her life); *Erickson* v. *Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962) (adult patient has the right to refuse a blood transfusion his doctor said was necessary to save his life); *In re Brooks' Estate*, 32 Ill.2d 361, 205 N.E.2d 435 (1965) (patient may refuse blood transfusion where the decision did not affect public health, safety or morals).

B. *The Right to Refuse Treatment has Never been Equated with Suicide by an Appeals Court or State Legislature and is Unrelated to any Purported Right to Physician Assisted Suicide.*

Both the Ninth and Second Circuit Courts of Appeals base their opinions on the finding that there is no difference between the act of refusing life-sustaining treatment and suicide. In this they are both wrong. Nonetheless, even though courts have repeatedly found that refusing treatment is not suicide, there is some language in two judicial opinions that show a confusion between refusing treatment and suicide. In *Georgetown College*, the judge states, with no analysis,

> where attempted suicide is illegal by the common law or statute, a person may not be allowed to refuse necessary medical assistance when death is likely to ensue without it. Only quibbles about the distinction between misfeasance and nonfeasance, or the specific intent necessary to be guilty of attempted suicide, could be raised against this latter conclusion.

331 F.2d at 1008-9.

This statement is startlingly incorrect. First, at the time it was made, neither the common law nor statutes made it a crime to attempt to commit suicide. Second, the distinction between misfeasance and nonfeasance is far from a quibble. Third, the issue of specific intent is a critical element to be guilty of a crime. Fourth, the judge recognized that the patient did not want to die, but rather death would be "an unwanted side effect of a religious scruple." 331 F.2d at 1009. Finally, the judge found that the patient was incompetent. Because she was not capable of making any decision, she could not attempt to commit suicide. Thus, the discussion of attempted suicide is both misinformed and irrelevant given the facts of the case.

The second case that confuses treatment refusal and suicide is strikingly similar in its lack of analysis. In *JFK Memorial*

Hospital v. *Heston*, 58 N.J. 576, 279 A.2d 670 (1971), the New Jersey Supreme Court ordered a blood transfusion for a 22-year-old Jehovah's Witness who was injured in an accident. In its decision the court said, "It seems correct to say there is no constitutional right to choose to die. Attempted suicide was a crime at common law and was held to be a crime [in New Jersey]. It is now denounced as a disorderly persons offense." 58 N.J. at 580, 279 A.2d at 672. Once again there was no analysis, merely an assumption that refusing treatment was the same as attempting suicide. Again the person in question was unconscious and therefore could not attempt suicide.

The courts that have actually analyzed this issue have readily distinguished refusing treatment from suicide. The same court that decided *Heston* later decided *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976). In that case, referring to *Heston*, the New Jersey Supreme Court wrote, "we would see, however, a real distinction between the self infliction of deadly harm and a self determination against artificial life support or radical surgery. . . ." 70 N.J. at 43, 355 A.2d at 665.

In a later case the New Jersey Supreme Court addressed the issue more directly, saying:

> declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury. . . . The difference is between self-infliction or self-destruction and self-determination. To the extent that our decision in *[Heston]* implies the contrary, we now overrule it.

In re Conroy, 98 N.J. 321, 350-51, 486 A.2d 1209, 1224 (1985).

All the courts that have enforced the right to refuse treatment have pointed out that the state may have compelling

interests that would allow it to abridge the exercise of that right. One of the avowed countervailing state interests is the prevention of suicide.[4] However no court has ever prevented a person from refusing treatment on the grounds that it would constitute suicide. Rather, *all* courts since *Quinlan* that have considered the issue distinguish between refusing treatment and attempting suicide. *See, e.g., Superintendent of Belchertown* v. *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). ("There is no connection between the conduct here at issue [refusing life-saving treatment] and any state concern to prevent suicide"); *Satz* v. *Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 4th Dist. 1978) (removing respirator from competent person would not be suicide but rather death from natural causes); *Bartling* v. *Superior Court*, 163 Cal. App.3d 186, 209 Cal. Rptr. 220 (2d Dist. 1984); *Matter of Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983); *Fosmire* v. *Nicoleau*, 75 N.Y.2d 218, 551 N.E. 2d 77, 551 N.Y.S. 2d 876 (1990) ("merely declining medical care, even essential treatment, is not considered a suicidal act").

[4] The other articulated state interests are the preservation of life, the protection of innocent third parties and the protection of the ethical integrity of the medical profession. The state's interest in the preservation of life has not been used to deprive individuals of their right to refuse treatment. Neither has the interest in the integrity of the medical profession been used this way. It had been thought that the interest in the protection of innocent third parties might cause courts to restrict the exercise of this right when the person refusing life saving treatment was the parent of a minor child. It has not been used this way, and courts have upheld the right of people with children to refuse treatment. *e.g, Fosmire* v. *Nicoleau*, 75 N.Y.2d 218, 551 N.E. 2d 77, 551 N.Y.S. 2d 876 (1990); *Norwood Hospital* v. *Munoz*, 409 Mass. 116, 564 N.E.2d 1017 (1991). This interest has been mistakenly used to attempt to prospectively restrict a treatment refusal of a woman during childbirth by one state supreme court. *Jefferson* v. *Griffin Spalding Co. Hospital Authority*, 247 Ga. 86, 274 S.E.2d 457 (1981). A more recent case has properly repudiated the use of force during childbirth as entirely unprincipled. *In re A. C.*, 573 A.2d 1235 (D.C. App. 1990). George J. Annas, Standard of Care 35-46 (1993). Given the regularity with which courts cite these state interests, it is notable that they have not been exercised in practice to limit the right to refuse treatment.

This makes sense when one considers the legal elements of suicide. To commit suicide one must (1) have the specific intent to die, and (2) intentionally set the death producing agent into motion. *Saikewicz*, 370 N.E.2d at 426, n.11. In all the refusing treatment cases the person refusing the treatment did not put the death producing agent into effect; death would be caused by the underlying medical condition which the person did not cause. *None* of the courts that have decided the right to refuse treatment cases have questioned the state's interest in the prevention of suicide. Rather, they all distinguish suicide from treatment refusal. The fact that a treatment refusal leads to death does not mean the patient's refusal of treatment is suicide.[5]

[5] The parties in the right to refuse treatment cases also understood the difference between refusing treatment and suicide. For example, Karen Ann Quinlan was a young woman in a persistent vegetative state, but not terminally ill. Her parents demanded that their daughter's ventilator be discontinued because they believed that is what she would have wanted. The doctors refused. The New Jersey Supreme Court, the country's first to decide a case involving withdrawal of life-sustaining medical technology (sometimes mistakenly called a "right to die" case) agreed that her wishes should be respected, and the ventilator was removed. Neither Ms. Quinlan nor her parents on her behalf, all devout Catholics, ever thought they were involved in suicide. The New Jersey Supreme Court carefully reviewed Catholic doctrine, which adamantly opposes suicide, assisted suicide, and euthanasia, but supports the right to refuse treatment. Pope Pius XII, in his Nov. 24, 1957 *allocutio*, said "that withdrawal or nonuse of mechanical ventilation ... is not to be considered euthanasia in any way; that would never be licit. The interruption of attempts at resuscitation, even when it causes the arrest of circulation, is not more than an indirect cause of the cessation of life; and we must apply in this case the principle of double effect." 70 N.J. at 31, 355 A.2d at 658. *See also* Amicus Curiae Brief of the Medical Society of New Jersey.

Similarly, in a New York case, Brother Joseph Fox, an elderly Catholic brother of the Society of Mary, said to his friend and confessor Father Philip Eichner, before surgery, words to the effect, "If I wind up like Karen Quinlan, pull the plug." *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S. 2d 266 (1981). Since suicide is a mortal sin in the Catholic Church, it is likely that Brother Fox would have been horrified at the notion that his refusal of a ventilator when in a persistent vegetative state (the condition he actually was in after unsuccessful surgery) constituted suicide. Ethics and theology, like the law, recognize the difference between refusing treatment and suicide.

The Second Circuit Court of Appeals holding is based entirely on equal protection analysis, and thus its conclusion is controlled by its finding that there is not even the most minimally rational distinction between refusing treatment and suicide. The Second Circuit Court of Appeals opinion states,

> [I]t seems clear that New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, *except for the previous attachment of life-sustaining equipment*, are not allowed to hasten death by self administering prescribed drugs.

80 F.3d at 728-9 (emphasis added).

This statement itself demonstrates that these classes of individuals are not similarly situated. One group is on life support, the other group is not. The fact that one group is on life support demonstrates that members of this group are being subjected to an ongoing bodily intrusion. This intrusion could only have taken place with their consent and, just as they could have refused the intrusion, they can withdraw their consent at any time. The circumstance that empowers the person on life-sustaining equipment to refuse further treatment is not the terminal illness, but the now undesired bodily intrusion. One need not be terminally ill to withdraw consent from an intrusion — one need only be intruded upon. Thus the "terminally ill" person *who is not on life support* is differently situated because he or she is not being subjected to an ongoing physical intrusion. Both have the same right to refuse treatment, although, as a practical matter, this right can only be exercised by one who is being treated or for whom treatment is recommended. In terms of the purported right to physician assisted suicide, the person on life support is treated identically to the person not on life support by the law: neither may have their suicide assisted by the provision of a prescription drug by their physicians (assuming that such an act by the physician is illegal at all).[6]

[6] It should be noted that no case has ever held that a physician who prescribes drugs a patient later uses to commit suicide is guilty of assisting suicide. No physician has ever been charged with such an offense. It is surprising that the Ninth Circuit Court of Appeals could simultaneously find that the doctors in Washington run a "severe risk of prosecution," 79 F.3d at 795, and that there is "no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death." 79 F.3d at 811. In its footnote 54, it describes two cases where physicians were charged with directly administering lethal injections to patients. While the court refers to these as assisted suicide cases, they were in fact homicide cases. Both physicians were acquitted.

It is unlikely that the mere prescription of drugs for a patient constitutes assisted suicide. The named plaintiff in the Second Circuit Court of Appeals case, Dr. Timothy Quill, admitted in an article published in a prestigious medical journal that he had prescribed a lethal dose of sleeping pills for a patient so she could decide at some future time whether or not to commit suicide with these pills. Timothy Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991). Based on this admission, a Grand Jury investigated the case and refused to indict. Furthermore, the New York Board for Professional Medical Conduct conducted an investigation to determine if Dr. Quill should be disciplined for his actions. The panel found Dr. Quill acted lawfully and appropriately. It noted that he could not determine with certainty what use the patient might make of the drugs he prescribed. Even if Dr. Quill prescribed the drugs believing they might be used by the patient to commit suicide, he did not participate in the taking of her life. The panel did not wish to interfere with the good medical practice of physicians who prescribe drugs to relieve a terminal patient's anxiety, insomnia or pain because the physician suspects the patient may later use the medication to terminate his or her life. *See*, John Alesandro, Comment, *Physician Assisted Suicide and New York Law*, 57 ALB. L. REV. 820, 823 n. 19 and 21 (1994). Thus, in the only case ever investigated that resembles the activities the plaintiffs claim are illegal in New York, the authorities ruled that the actions were lawful.

It must be kept in mind that the activity in question is the prescription of drugs by physicians. Once the prescription is written the patient must decide whether to fill it, and then must decide whether to use the drugs for the lawful purpose for which a prescription is written, such as relief of insomnia, or to take these drugs to commit suicide. These decisions all occur over a lengthy period of time. Thus there is a long and tenuous chain of events between the writing of the prescription and its use for suicidal purposes.

This is quite different from prosecuted assisted suicide cases, where there is a close link between the assistance and the act of suicide. In one case a defendant helped her sister to commit suicide by attaching a vacuum

Both the Second and the Ninth Circuit Courts of Appeals rely heavily on the termination of artificial nutrition and hydration cases to support the proposition that there is no difference between a physician who complies with a patient's right to refuse treatment and a physician who assists suicide. 79 F.3d at 822-823, 80 F.3d at 729. They argue that a person like Nancy Cruzan does not die of her underlying condition but rather of an independent cause, starvation. This is simply incorrect. When a person requires the administration of artifi-

cleaner hose to the end of an exhaust pipe of a car, gave her sister the other end of the hose, said good-bye and closed the garage door as she left. In another case a husband helped his cancer ridden wife commit suicide by preparing an overdose of sedatives, sitting with her while she ate it, and helping her put a plastic bag over her head. Catherine Shaffer, Note, *Criminal Liability for Assisting Suicide*, 86 COLUM. L. REV. 348, 366, n. 77, 79 (1986). In these cases, and others cited in the article, the "assistance" that was found to be unlawful was much more direct than writing prescriptions, much closer in time to the commission of the suicide, and led directly to the suicide. At least three of the six patient-petitioners in these two appeals were not suicidal at the time they signed their declarations, but rather wanted exemptions from the drug laws so that they could have their physicians write them prescriptions for lethal drugs that they *might* use at some time in the future to commit suicide *if* their suffering became intolerable. 79 F.3d 794-5; 80 F.3d 720-21.

It is notable, given the relief sought in this case by the plaintiffs, that no court has actually concluded that writing a prescription constitutes assisting suicide. Perhaps the federal courts should have remanded the issue to the state courts for a definitive interpretation of the statutes in question. Both statutes are written in general terms and neither explicitly forbids physicians from writing prescriptions for their patients. Furthermore, it may have been possible for the federal courts to have interpreted the statutes in a way that would have made it unnecessary for them to decide the constitutional question. *Communications Workers of America* v. *Beck*, 487 U.S. 735, 762 (1988).

Interestingly, the Ninth Circuit opinion states "we are doubtful that deaths resulting from terminally ill patients taking medication prescribed by their doctors should be classified as 'suicide'." This is likely to be correct, and if it is correct then there is no need to resolve whether there is a constitutional right to assistance. If writing a prescription for drugs a patient may or may not use at some unspecified future time to commit suicide does not constitute assisted suicide under state law, then physicians may prescribe such drugs for their terminally ill patients without any constitutional determination by a federal court.

cial forms of nutrition and hydration for his continued existence, this is beacuse, by definition, he suffers from a condition that prevents him from eating and drinking in a normal fashion. In the absence of medical treatment that provides artifical nutrition and hydration, the person would die from the lack of nutrition or hydration which is itself caused by the disease or condition. Thus, terminating artifical nutrition or hydration is no different from terminating any other medical treatment including artifical respiration, kidney dialysis or chemotherapy.[7] Termination of treatment returns the person to the status quo prior to the bodily intrusion. Subsequently, in the absence of these intrusions, the disease takes its course.

This is in stark contrast to assisted suicide. In such a case the person dies from a cause entirely external to the disease or condition from which the person suffers. If a person has cancer or AIDS, the person will not die from a barbiturate overdose, potassium chloride poisoning, or carbon monoxide poisoning unless these foreign substances are introduced into the person's body. If the substances are introduced, then death would be caused by poisoning, and not by the disease process taking its course.

The failure to distinguish real causes of death from the medical tools and techniques that may temporarily substitute for particular bodily functions is fatal to the logic of both of these opinions. If one were to accept that Nancy Cruzan "died of

[7] "Artifical feeding cannot be distinguished from other forms of medical treatment . . . the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artifical delivery of food and water." *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261, 288-289 (1990) (O'Connor, J., concurring); "artifical feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle-feeding or spoonfeeding — thay are medical porcedures with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning," *In re Conroy*, 98 N.J. 321, 373, 486 A.2d 1209, 1236 (1985).

starvation" and not from the vegetative condition that made it impossible for her to eat or drink, one would also have to accept the conclusion that when physicians stop attempted cardiopulmonary resuscitation on a patient in cardiac arrest, what kills the patient is not the cardiac arrest but rather the physician who intentionally stops compressing the heart. Since the failure to perform cardiopulmonary resuscitation always "hastens death," under each court's logic, patients who refuse cardiopulmonary resuscitation would always be committing suicide.

Similarly, the Ninth Circuit Court of Appeals wrongly assumes that physicians who administer drugs for pain relief that could also shorten life *intend* the death of the patients. 79 F.3d at 827. This indicates that the Ninth Circuit Court of Appeals misunderstands the principle of the double effect, in which an action may have two known consequences, only one of which is intended. Thus, the conclusion that pain relief and death are equally intended by a physician who administers a pain-relieving drug that may also shorten life is false. Physicians titrate pain relieving drugs in an attempt to provide maximum effective pain relief without causing death. The principle of the double effect means that treating the patient's pain is acceptable even if the treatment may hasten death. Providing medication to control pain has always been a legitimate and lawful medical act, even if death or suicide is risked. Most invasive medical interventions carry the risk of death or disability. But if a patient dies during surgery, the surgeon is not guilty of homicide. This is because there is a real difference between an intended result and an unintended but accepted consequence of medical care where the goal is to benefit the patient.[8] The difference between

[8] As one of the dissenting judges, Andrew Kleinfeld, in the Ninth Circuit Court of Appeals opinion, properly notes, when General Dwight D. Eisenhower ordered American troops to the beaches in Normandy, he knew he was sending many to certain death, but his purpose was to liberate Europe from the Nazis. Judge Kleinfeld continued, "The majority's theory of ethics would imply that this purpose was legally and ethically indistinguishable from a purpose of killing American soldiers." 79 F.3d at 858 (Kleinfeld, J., dissenting).

intended and unintended but foreseen consequences of medical treatment was also addressed by the first presidential bioethics commission. It concluded that the relevant moral issue:

> . . . is not really that death is forbidden as a means to relieve suffering but is sometimes acceptable if it is merely a foreseeable consequence. Rather, the moral issue is whether or not the decisionmakers have considered the full range of foreseeable effects, have knowingly accepted whatever risk of death is entailed, and have found the risk to be justified in light of the paucity and undesirability of other options.

PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 82 (1983).

There are other important differences between assisted suicide and refusing treatment. Unlike assisted suicide there are currently no statutes, and there have never been any statutes, that prohibit a person from refusing treatment. Nor have any statutes been necessary to grant individuals the right to refuse treatment.[9] The case law that exists in this area did not come about as a result of individuals attempting to invalidate state law. Rather the case law was developed because individuals were being denied their right to refuse treatment by other individuals, or because someone brought an action in an

[9] All states have adopted "Natural Death Statutes," "living will" laws, health care proxy laws, durable power of attorney laws or similarly entitled statutes. These are all for the purpose of enabling decisionmaking on behalf of *incompetent* persons. They have no relevance to the issue of a competent person's right to make health care decisions for him- or herself except as they extend this right into the state of incompetence.

attempt to force treatment on an unwilling person. Thus, unlike the assisted suicide cases before the Court, the courts have not been asked to invalidate legislative judgments in the refusing treatment cases. Even in *Cruzan*, this Court was not asked to rule on a statute, but on a burden of proof standard that was created by a state supreme court. Moreover, neither the Missouri Supreme Court nor this Court even raised the question of whether withdrawing Nancy Cruzan's feeding tube based on her wishes would violate Missouri's law against physician assisted suicide. The relevance of this to the instant case is to note that legislatures across the county have prohibited assisted suicide but have never prohibited competent persons from refusing treatment. This in and of itself is strong evidence of the difference between treatment refusal and suicide.

The right to refuse treatment is an expression of the patient's autonomy and the right to refuse unwanted bodily invasions. Any competent adult can refuse treatment for any reason. The right of a competent person to refuse treatment has never been conditioned on having a terminal illness or any other medical status. Nor does a patient need the permission or cooperation of a physician to refuse treatment. If a person refuses treatment, the physician may not lawfully treat the person. If the patient withdraws consent to treatment, the physician must cease to treat the person.

In contrast, the purported "right" to physician assisted suicide in the instant cases is defined entirely by a physician's subjective assessment of the patient's circumstances. The person must be found to be "terminally ill" (an undefined and undefinable term), must be in a condition where death will soon occur, and must be suffering in a way a physician finds distressing enough to prescribe the desired drugs. This is unrelated to the right of all individuals to refuse treatment for their own reasons. This Court should affirm the right to refuse treatment and make clear that rejection of the purported right to assisted suicide does not in any way undermine the right to refuse treatment.

II. The Constitutional Right Of Pregnant Women To Terminate A Pregnancy Is Based On Facts And Constitutional Principles That Do Not Encompass Any Asserted Constitutional Right To Physician Assistance In Suicide.

A. *The Constitutional Right of a Pregnant Woman to Terminate her Pregnancy is Based on her Interest in her own Life, Health, and Future.*

The Ninth Circuit Court of Appeals saw no difference between the woman's interest in continuing or terminating a pregnancy, and a terminally ill person's interest in obtaining assistance in committing suicide, finding both "central to personal dignity and autonomy." 79 F.3d at 813-814. But this parallel could be drawn only by misunderstanding the fundamental basis on which the abortion cases have been decided. Constitutional protection of a woman's right does not require also protecting a right to physician assisted suicide.

The Ninth Circuit Court of Appeals reached its conclusion that there is a substantive due process right to determine "the time and manner of death" almost solely on the basis of the following two sentences from the joint opinion in *Planned Parenthood* v. *Casey*, 505 U.S. 833, 851 (1992).

> "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."

79 F.3d at 813.

Unlike the Ninth Circuit, however, the joint opinion in *Casey* continued its reasoning after the two sentences quoted above, saying, "These considerations begin our analysis . . . but cannot end it. . . ." 505 U.S. at 852. In *Casey*, as in earlier decisions, this Court recognized a constitutional right related

to "marriage, procreation, contraception, family relationships, child rearing, and education." 505 U.S. at 851. In *Casey*, the Court reaffirmed "the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to bear or beget a child." 505 U.S. at 851. This choice is so central to a woman's life, health, future, and place in society that only she should be able to make it. This is because, as the joint opinion in *Casey* explained, "abortion is a unique act ... [T]he liberty of a woman is at stake in a sense unique to the human condition and so unique to the law ... The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society." 505 U.S. at 852.

The reasons for protecting a woman's right to choose to continue or terminate a pregnancy simply do not apply beyond pregnant women. A woman's decision whether to have a child determines not only her future relationships with others but her own conception of herself and her role in society. Furthermore, the constitution protects the woman's right in order to ensure that women are treated fairly as free and equal participants in a democracy. ("The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." 505 U.S. at 856). The woman's right is thus "implicit in the concept of ordered liberty." *Palko* v. *Connecticut*, 302 U.S. 319, 325 (1937).

None of these reasons apply to a person who seeks assistance in committing suicide. A decision to commit suicide does not further the goals of reproductive liberty, equality and full participation in the "economic and social life of the nation," values preserved by the Court in *Casey*. Therefore, the Second Circuit Court of Appeals was correct to reject a substantive due process right to assistance in suicide based on the abortion cases. 80 F.3d at 725.

B. *Unlike Other Aspects of Personal Life That Have Been Protected From State Interference by the Constitutional Right of Privacy or Personal Liberty, the Right to Physician Assisted Suicide Is Poorly Defined and Its Exercise Cannot be Limited by Logic or Principle.*

The very core of the constitutional privacy and liberty cases is that individuals have "zones of privacy" into which the government may not enter. These involve decisions that are so personal and important to the individual, and which do not affect the general public, that government simply has no role in limiting the decisions an individual might make in these areas. *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), *Carey* v. *Population Services*, 431 U.S. 678 (1977). *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972). In *Griswold*, by outlawing the use of contraceptives, the state required married people to risk pregnancy or to refrain from marital sexual relations. *Griswold* forbade the state from invading the marital bedroom and controlling the activities that occurred there. In *Eisenstadt* and *Population Services*, the Court extended *Griswold* by properly noting that the decision whether or not to bear or beget a child is a *personal* right that is reserved to every person, and that the state has no role in that highly personal decision. Likewise, in *Roe* v. *Wade*, 410 U.S. 113 (1973), and its progeny, including *Casey*, the Court has continued to recognize this zone of privacy into which the state could not intrude.

What is notable about this line of cases, and the cases which supplied the conceptual foundation for them, *Loving* v. *Virginia*, 388 U.S. 1 (1967), *Stanley* v. *Georgia*, 394 U.S. 567 (1969) and *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925), is that they involved discrete decisions, made by members of a readily identifiable category of individuals, who did not have to justify the reasons for their decisions.

Prior to *Roe*, there were states that permitted a woman to terminate pregnancy if she had a reason the state found

acceptable. Some states permitted a woman to terminate her pregnancy if it endangered her life; others if it endangered her health. Still other states allowed termination of pregnancy if the woman was impregnated as a result of rape or incest, or if the fetus was malformed enough to satisfy the state. The essential underpinning of *Roe* is that it is not for the state to determine whether a woman's reason for terminating her pregnancy is legitimate; rather only the woman herself can make this very private, personal and life changing decision. Because the reasons are so personal, she need not give a reason. This is also true of other decisions that this Court has recognized are protected by the constitutional rights of personal privacy and liberty. Thus, no one needs to justify to the state their reasons for wishing to use contraceptives, or to send their child to a parochial school, or to marry a person of a different race.

In a similar respect, it is clear who comes under the protective umbrella of the right of privacy or personal liberty as applied by this Court. *Every* pregnant woman may choose whether or not to terminate her pregnancy; *every* person who engages in sexual activity may choose whether or not to use contraceptives; *every* parent may choose what type of school their child attends; *every* person may decide whom to marry regardless of race.

In its conclusion, the Ninth Circuit Court of Appeals says, "We hold that a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors, violates the Due Process Clause." 79 F.3d at 838. In stark contrast to contraception, abortion and marriage rights, the scope of the right to assisted suicide as portrayed by the Ninth Circuit Court of Appeals is not ascertainable.

Moreover, unlike the broad classes of people to whom other liberty rights apply, the "right" to suicide assistance described

by Ninth Circuit Court of Appeals only applies to "terminally ill" people. Unlike pregnant women, for example, this is not an objectively definable class. Arguably, anyone who is diagnosed with an incurable, lethal disease is terminally ill. Thus, an AIDS patient with a life expectancy of five years, an 18-year-old with cystic fibrosis and a twelve year life expectancy and a cancer patient who is in the final stages of a disease, are all "terminally ill." In some places the Ninth Circuit Court of Appeals describes a terminally ill patient as one who has an "incurable and painful degenerative disease" that leads to "debilitating pain and humiliating death." 79 F.3d at 821. Elsewhere the court describes patients "wracked by pain and deprived of all pleasure." 79 F.3d at 814. Still elsewhere the court argues that a person who is "reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent," has "a strong liberty interest in choosing a dignified and humane death." 79 F.3d at 814. Obviously these are people who are suffering from different conditions.

The Ninth Circuit Court of Appeals itself acknowledges that the term "terminally ill" does not constitute a "clear line of demarcation." 79 F.3d at 830. But the court draws comfort from the fact that some states in their "natural death laws" have defined terminal illness as meaning death is likely to ensue in six months. It is remarkable that the Ninth Circuit Court of Appeals creates a constitutional right for a class it cannot define in any principled way because some state legislatures have adopted an arbitrary definition (and one that applies to differently-situated people for different reasons). This is a dramatic departure from the thoughtful and precise way this Court has applied the constitutional right of privacy or liberty in other contexts.

The Ninth Circuit Court of Appeals also seems to believe that, unlike the exercise of other rights in this area, it can require people to justify their individual exercise of this right. Thus the court imperiously asserts that a forty-year-old alcoholic has no right to physician assisted suicide but does not explain why his suffering does not entitle him to the rights

the court grants other suffering patients. 79 F.3d at 821. Assume that this person has struggled with his alcoholism for 20 years, has lost his job and family as a result of his drinking, and has repeatedly undergone unsuccessful treatment. Why does the court think that *it* or the *state* can determine that this person's very real, ongoing and life long suffering and humiliation do not meet the constitutional requirements for assisted suicide, but that a cancer patient's suffering at the end of life does? No constitutional principle can distinguish these two cases.

This is not a "slippery slope" argument. The point is that if assisted suicide is a constitutionally protected right to end suffering, then neither the courts nor the states should be able to say how much suffering is enough. That is necessarily a personal judgment to be made by the individual. The very failure of the Ninth Circuit Court of Appeals to recognize this point demonstrates that the "right" to assisted suicide is not like the right to choose to terminate pregnancy or the right to use contraception, and thus is not related to the privacy and liberty rights this Court has previously recognized.

C. *Any Purported Constitutional Right to Physician Assistance in Suicide does not Follow from a Woman's Right to Terminate a Pregnancy because (1) Assistance in Suicide is not a Medical Procedure; and (2) Regulating Physician Assisted Suicide would Require Intrusions into the Physician-Patient Relationship that have been Rejected as Unconstitutional in Implementing a Woman's Decision to Terminate a Pregnancy.*

1. *Assistance in Suicide is not a Medical Proedure.*

Abortion is and has always been a medical procedure, and thus only licensed physicians may lawfully perform abortions. *Roe* described "the abortion decision in all its aspects" as "inherently and primarily a medical decision." 410 U.S. at 165. Unlike abortion, assisting a suicide requires no special

medical skills or knowledge. Assisting patients to commit suicide is not taught in medical schools, tested on any medical board examinations or discussed in the standard medical texts. Self-abortions and abortions done by nonphysicians are dangerous to women's lives and health. The safety of suicide is not an issue. Almost all competent adults are capable of successfully committing suicide, and tens of thousands do so every year in the United States. Assisting suicide is not a medical procedure, and medicalizing an act runs the risk of making an otherwise unacceptable act appear acceptable. The country's most notorious practitioner of assisted suicide, Jack Kevorkian, uses carbon monoxide poisoning, a method that is entirely nonmedical in nature. George J. Annas, *Physician Assisted Suicide — Michigan's Temporary Solution*, 20 Ohio N. U. L. Rev. 561, 568 (1994). Although Kevorkian's medical license has been revoked, no one has ever argued that he should be prosecuted for the unlawful practice of medicine. This is because assisted suicide is not the practice of medicine, and does not require any medical knowledge or access to any medical drugs or devices. The Ninth Circuit Court of Appeals itself recognized that physicians need not be involved in the final act of assisted suicide by extending immunity to cover family members and other nonphysicians. 79 F.3d at 839. This is why, unlike laws against abortion, laws against physician assisted suicide do not have a unique impact on physicians.

The Ninth Circuit Court of Appeals could not explain why the constitutional right to assisted suicide, a right that purportedly belongs to the "terminally ill" person, can or should be limited to assistance by physicians, or to one particular suicide assistance technique, namely prescribing drugs. Unlike abortion, suicide can be accomplished in many nonmedical ways. If there is a right to commit suicide with prescription drugs, then there must also be a right to commit suicide using a gun, if that is what the terminally ill patient so desires. There is no principled way to distinguish between methods of suicide, and it is impossible to create a constitutional right to commit suicide using one means but not another. Indeed,

it is likely, given the lack of training physicians receive in this area, that a person could receive more effective assistance in suicide from an executioner than from a physician.

In 1989, a similar Amicus group of bioethics professors argued to the Court that the constitutional right of privacy protects a woman's right to make the personal medical decision whether to terminate a pregnancy in the privacy of the physician-patient relationship, free from state intrusion. Brief for Bioethicists for Privacy as Amicus Curiae Supporting Appellees in *Webster* v. *Reproductive Health Services*, No. 88-605 (reprinted in the Joint Appendix accompanying *Washington* v. *Glucksberg*, No. 96-110, at 95-127). Amicus believes that the arguments made there remain valid. Nonetheless, accepting them does not require the Court to protect any right to assisted suicide because the decision to commit suicide or to request assistance in suicide is not a personal *medical* decision, and because assisted suicide is not a *medical* procedure.

Assisted suicide is not like abortion. In abortion, the Court protected an activity that necessarily occurred in the confines of the private physician-patient relationship. In assisted suicide, neither physicians nor medical procedures are necessary. Thus, unlike abortion, limiting the right of assisted suicide to aid by physicians is illogical, arbitrary, and not derived from any constitutional principle.

2. *Regulating Physician Assisted Suicide would Require Intrusions into the Physician-Patient Relationship that have been Rejected as Unconstitutional in Implementing a Woman's Decision to Terminate a Pregnancy.*

Abortion is performed in the context of a confidential physician-patient relationship without direct state or third party interference or review. Protection of the right to decide whether to terminate a pregnancy requires keeping the states out of this confidential relationship. In contrast, all proposals to "legalize" physician assisted suicide require or encourage

intrusions into the physician-patient relationship by mandating outside review and approval of the patient's decision. Daniel Callahan & Margot White, *The Legalization of Physician Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Richmond L. Rev. 1, 8-9 (1996). Both Circuit courts called on states to regulate physician assisted suicide to prevent abuses, and the Ninth Circuit Court of Appeals seemed to endorse Oregon's law, the only existing state law on the subject in the U.S. Or. Rev. Stat. §127.800 et seq. (1995).

The Oregon law grants legal immunity for physicians who prescribe lethal medications for their competent terminally ill patients (defined as those with 6 months or less to live) who express a desire to use these drugs to commit suicide. However, prior to writing the prescription, the physician must obtain a request for the prescription, in writing and signed in the presence of at least two witnesses who certify that the patient is competent and acting voluntarily. In addition, at least two physicians must agree that the patient is likely to die from a terminal illness within six months and the patient must be referred for psychiatric or psychological counseling. Finally, waiting periods are built in: two oral requests are required, the second no less than 15 days after the original oral request, and the prescription itself cannot be provided less than 48 hours after the written request. Under *Doe* v. *Bolton*, 410 U.S. 179 (1973), this burdensome and intrusive procedure would not be constitutionally permissible if the right to physician assisted suicide is based on a fundamental liberty interest; in abortion no one gets to second guess the woman's constitutionally-protected decision.

Unlike abortion, physician assisted suicide is recognized, even by the two Circuit Courts of Appeals that have asserted that it is a constitutional right, as far too dangerous a right to be exercised by patients and physicians alone.

The conclusion is inescapable: the woman's right to make decisions regarding abortion is unique, and unlike assisted suicide, protects the life, health, and future well being of women.

CONCLUSION

Amicus therefore respectfully requests this Court to:
1) Reverse the judgment of the Ninth Circuit Court of Appeals,
2) Reverse the judgment of the Second Circuit Court of Appeals,
3) Explicitly recognize that rejection of a constitutional right to physician assistance in committing suicide in no way affects the common law and constitutional right to refuse medical treatment,
4) Explicitly recognize that rejection of a right to physician assistance in committing suicide in no way affects a woman's constitutional right to determine whether or not to terminate her pregnancy.

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